Early Results of a Marketwide ACO Initiative: The Alternative Quality Contract (AQC)

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Twin Goals of Improving Quality & Outcomes While Significantly Slowing Spending Growth

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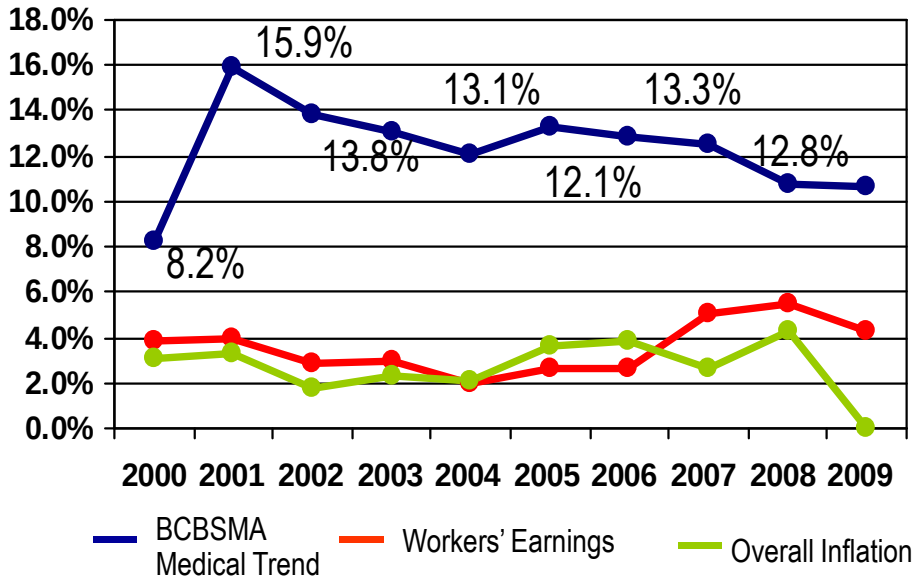
In 2007, leaders at BCBSMA challenged the company to develop a new contract model that would improve quality and outcomes while significantly slowing the rate of growth in health care spending.

MA individual mandate (2006) caused a bright light to shine on the issue of unrelenting double-digit increases in health care spending growth.



Sources: BCBSMA, Bureau of Labor Statistics

Key Components of the AQC Model

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Unique contract model:

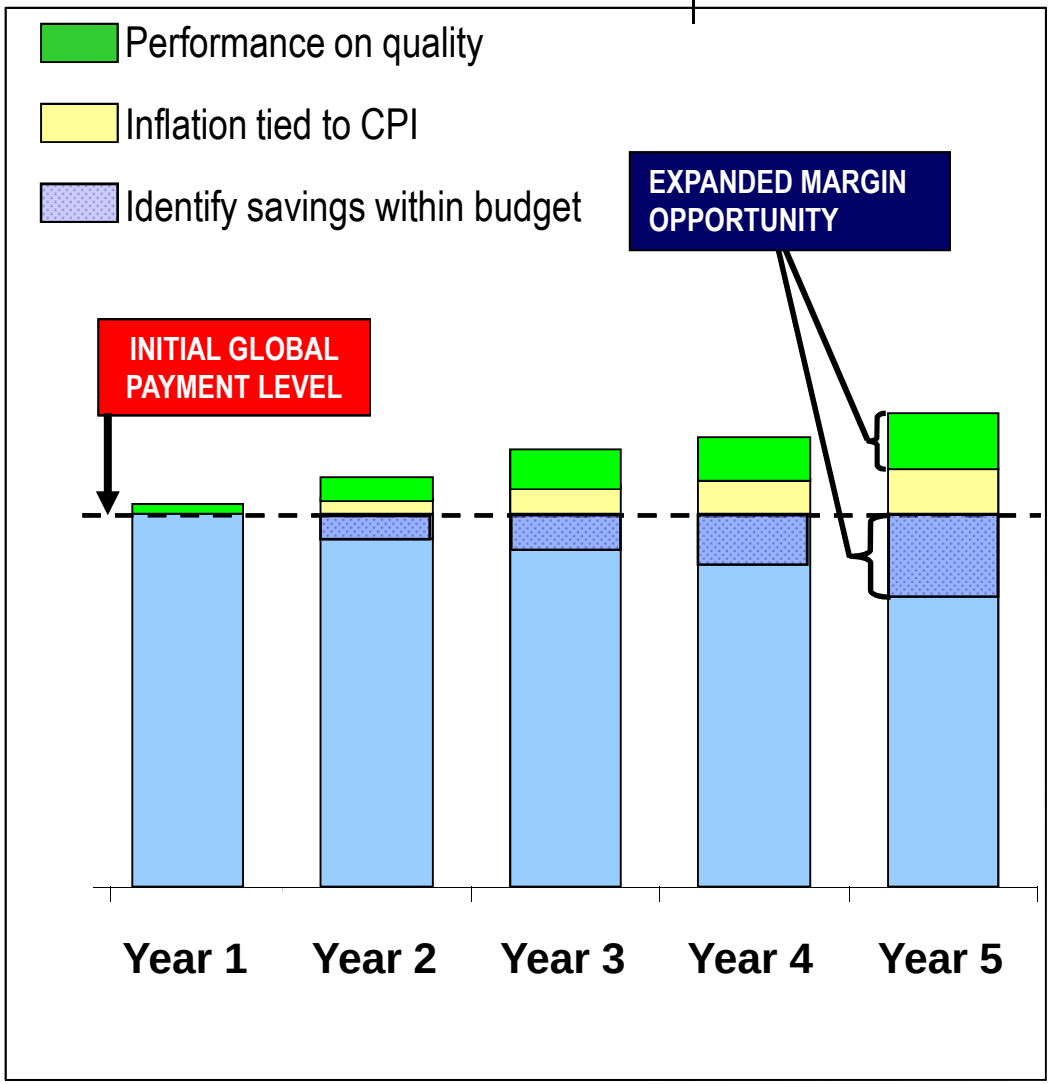
- Accountability for quality and resource use across full care continuum
- Long-term (5-years)

Controls cost growth:

- Global payment
- Annual inflation tied to CPI
- Incentive to eliminate clinically wasteful care ("overuse")

Improved quality, safety & outcomes:

- Robust performance measure set creates accountability for quality, safety & outcomes across continuum
- Substantial financial incentives for high performance



AQC Measure Set for Performance Incentives

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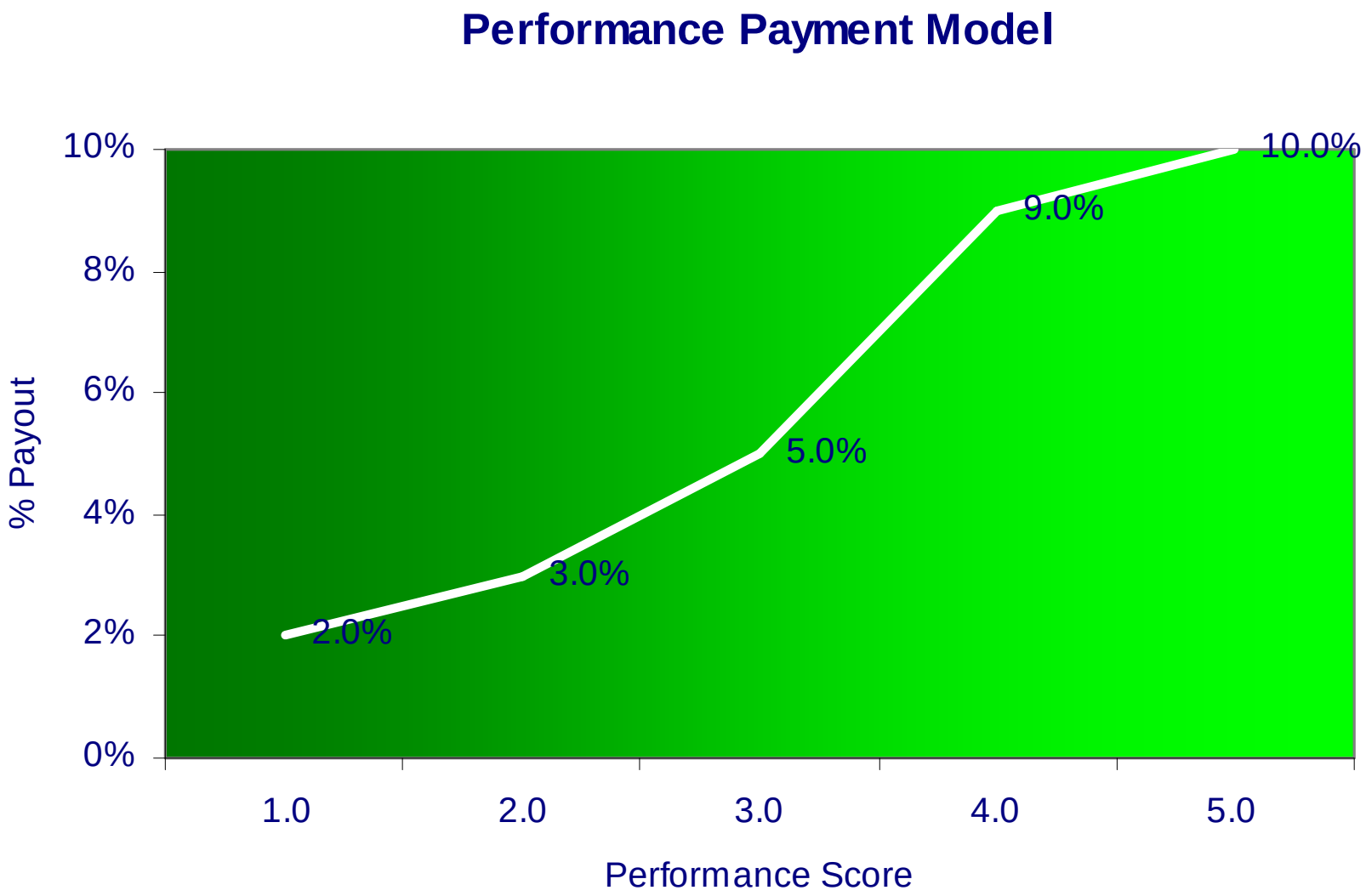
	AMBULATORY	HOSPITAL

PROCESS	• Preventive screenings
	• Acute care management
	• Chronic care management
	  • Depression
	  • Diabetes
	  • Cardiovascular disease
		• Evidence-based care elements for:
		  • Heart attack (AMI)
		  • Heart failure (CHF)
		  • Pneumonia
		  • Surgical infection prevention

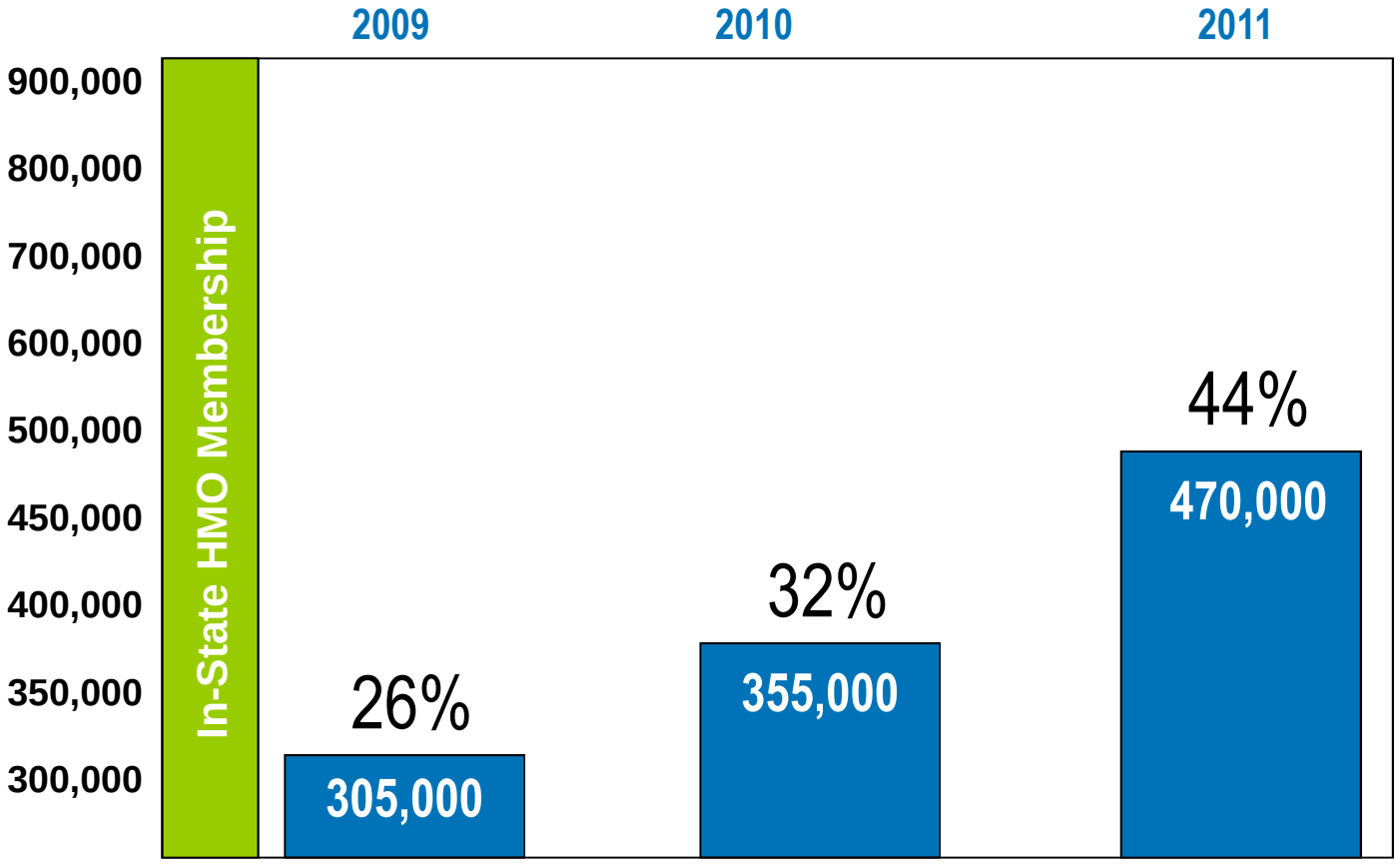
OUTCOME	• Control of chronic conditions
	  • Diabetes
	  • Cardiovascular disease
	  • Hypertension
	  • ******Triple weighted******
		• Post-operative complications
		• Hospital-acquired infections
		• Obstetrical injury
		• Mortality (condition –specific)

PATIENT EXPERIENCE	• Access, Integration • Communication, Whole-person care	• Discharge quality, Staff responsiveness • Communication (MDs, RNs)
DEVELOPMENTAL	Up to 3 measures on priority topics for which measures lacking	

Performance Achievement Model



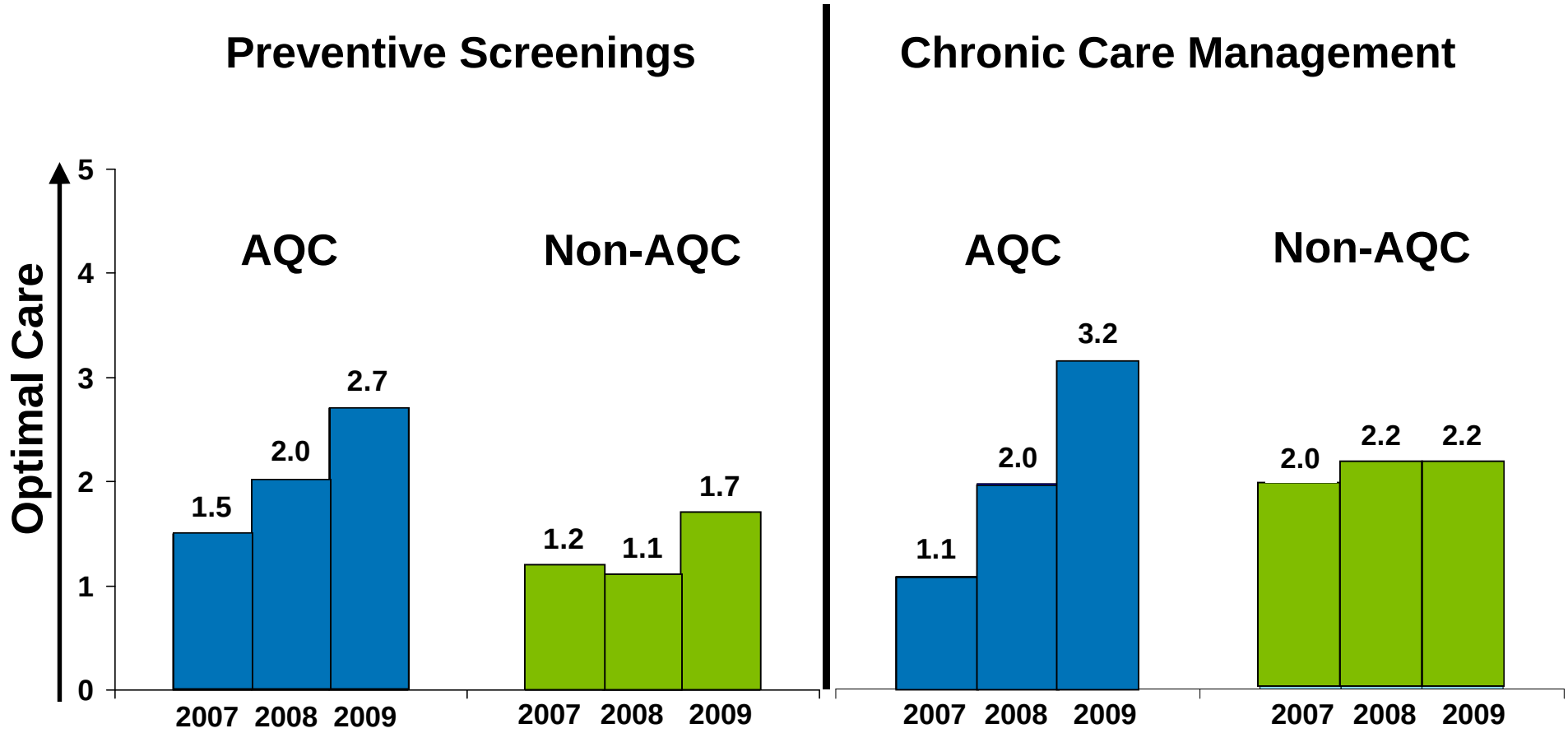
Significant Growth, 2009-2011



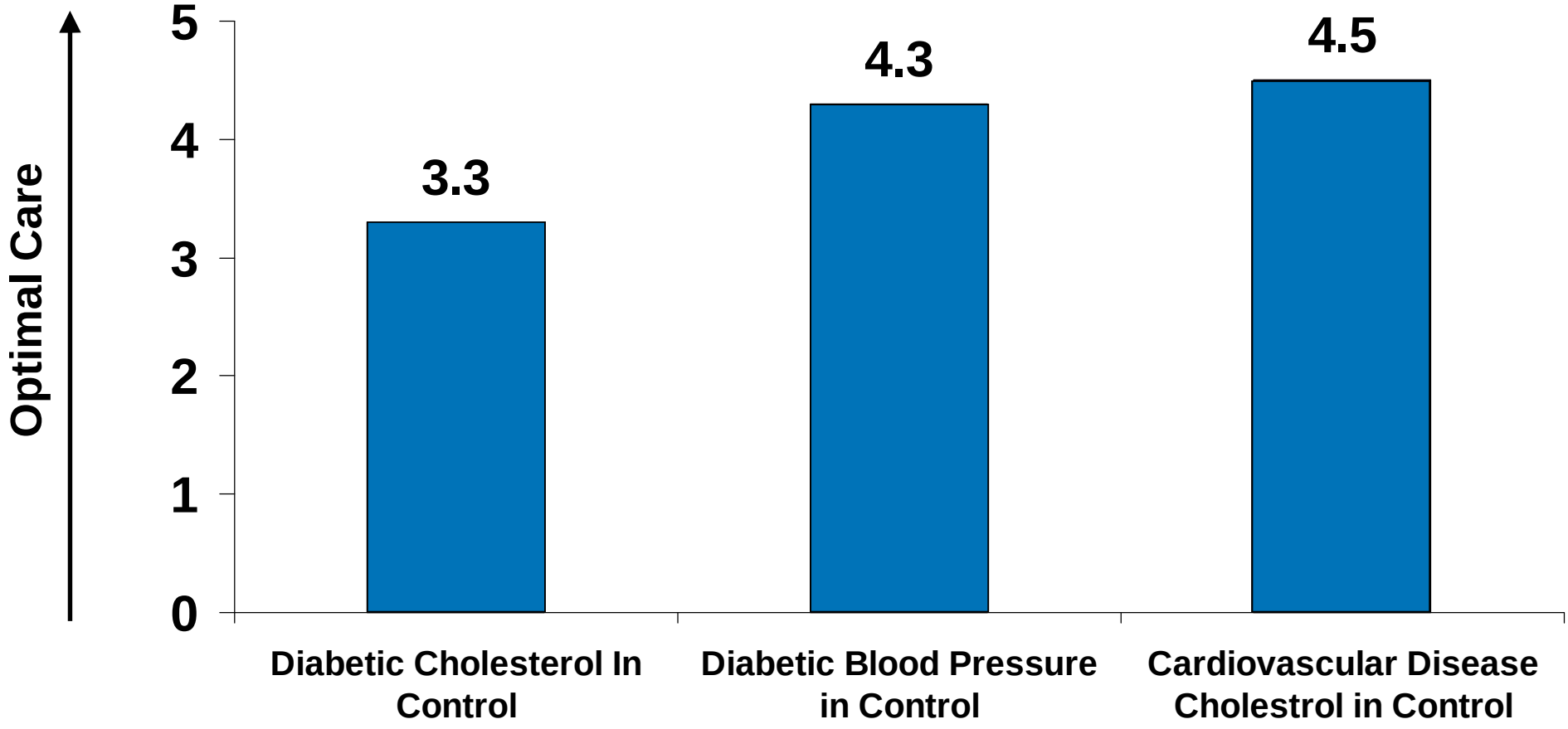
First Year Results show the AQC is Improving Quality

- Year-1 improvements in the quality were greater than any one-year change seen previously in our provider network
- Every AQC organization showed significant improvement on the clinical quality measures, including several dozen clinical process and outcomes measures
- For important preventative care measures, like cancer screenings and well-child visits, as well as for important measures of chronic disease care, *AQC groups' performance was three times that of non-AQC groups* and *more than double* the AQC groups' own improvement rates before joining the AQC.
- AQC groups exhibited exceptionally high performance for all clinical outcome measures with *more than half approaching or meeting the maximum performance target* on measures of diabetes and cardiovascular care
- There were no significant changes in AQC groups' performance on patient care experience measures overall.

AQC Groups Surpass Network on Key Preventive and Chronic Care Measures



AQC Groups Achieving Excellent Outcomes for Patients with Chronic Disease



Results limited to AQC groups that received financial incentives for these measures in 2009.

First Year Financial Results

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- AQC is on track to reach achieve the goal of reducing cost trends by 50% over 5 years
- All AQC groups produced budget surpluses that enable them to make infrastructure investments and delivery system changes to further improve quality & efficiency.
- Year-1 savings largely achieved through attention to site-of-service issues (price), but the more complex and difficult work of reducing use is also advancing
  - Groups have begun reducing non-urgent ER visits – one group by 22% -- by promoting urgent care centers or offering after-hours appointments, and by identifying additional supports for patients with unusually higher ER use.
  - Groups are reducing hospital readmissions – one group by 15% -- by increasing contact between patient and physician's office after hospitalization, reviewing re-admission data and working directly with hospitals to address causes of re-admissions, and in some cases, making home visits for patients particularly vulnerable to re-admission. For non-AQC groups, readmission rates increased over the same time period.

Example of Account-Specific Report on the Value of AQC

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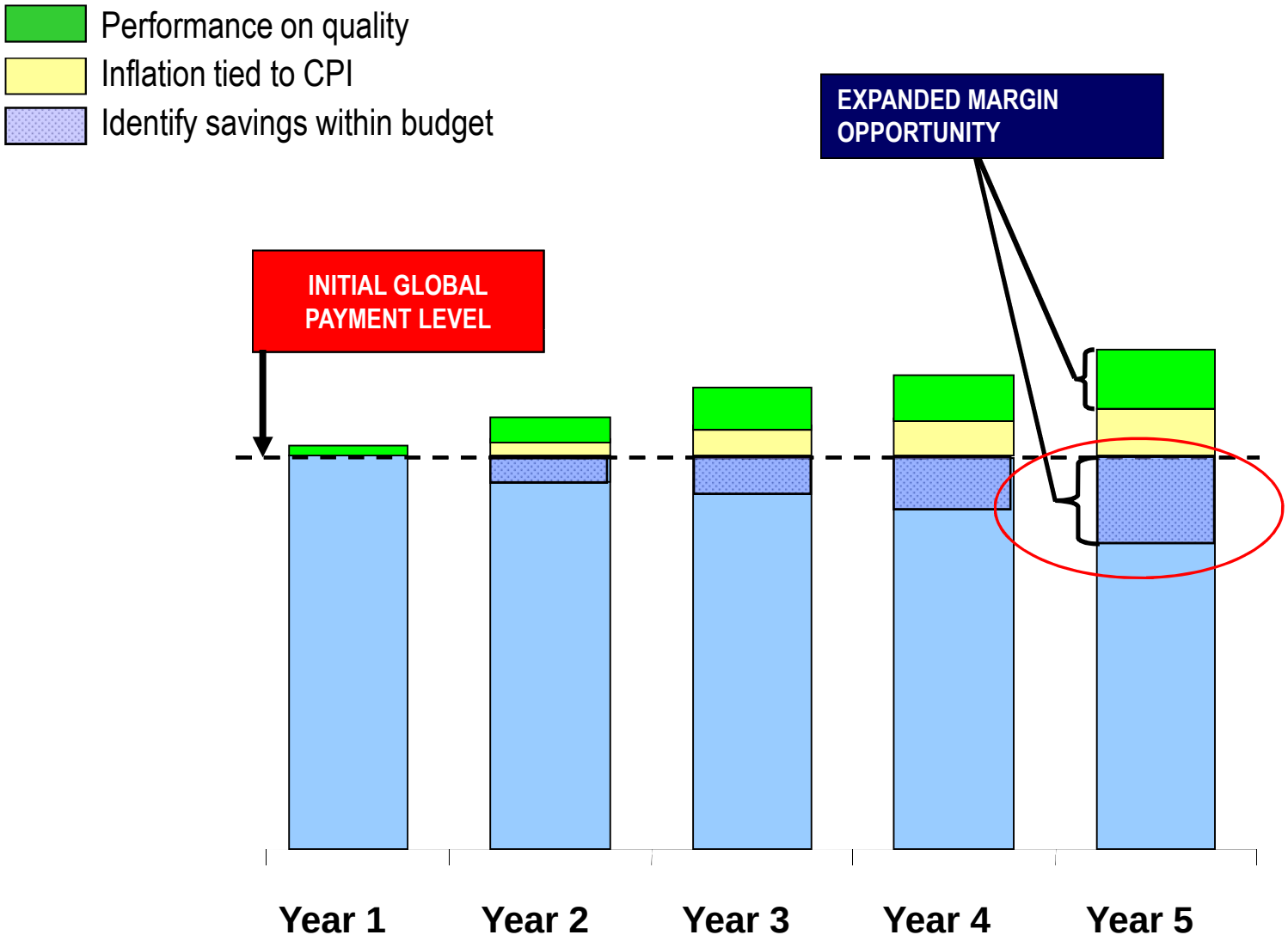
Measure	CY2010 Performance Score	
	PCP in AQC CY10 Score	PCP Not in AQC CY10 Score
QUALITY	**%**	**%**
Preventive Care & Screenings	☆☆☆	☆☆
Breast Cancer Screening	82.5*	79.9
Cervical Cancer Screening	85.8*	81.4
Colorectal Cancer Screening (51 - 80)	69.9*	67.6
Chlamydia Screening		
Ages 16-20	63.9*	58.1
Ages 21-24	64.3*	62.4
Chronic Care Management	☆☆ 1/2	☆☆
Depression		
Acute Phase Rx	66.8	66.6
Continuation Phase Rx	51.8	49.6
Cardiovascular		
LDL-C Screening	89.8	88.9
Diabetes		
HbA1c Testing (2X)	75.1*	70.2
Eye Exams	64.9*	61.8
Nephropathy Screening	86.0*	81.5
Diabetes LDL-C Screening	89.6*	86.6
Acute Care Management		
Acute Bronchitis	26.7*	20.0
Pediatric Care	☆☆☆	☆☆
Upper Respiratory Infection (URI)	93.4*	94.3
Pharyngitis	95.7*	92.6
< 15 months Well Care Visits	91.5*	86.6
3-6 Years Well Care Visits	93.6*	88.4
Adolescent Well Care Visits	74.5*	70.2
RESOURCE USE		
Non-emergent/PCP Treatable ED Visits per 1000 [1]	115.28	127.44
30-Day All Cause Readmissions (not risk-adjusted)	10.2%	10.0%
Admissions per 1000 (not risk-adjusted)	42	31

RED = AQC performance unfavorable when compared to non-AQC performance

WHITE = No difference in performance

GREEN = AQC performance favorable when compared to non-AQC performance

Key Components of the AQC Model



Identifying & Addressing Clinically Wasteful Care

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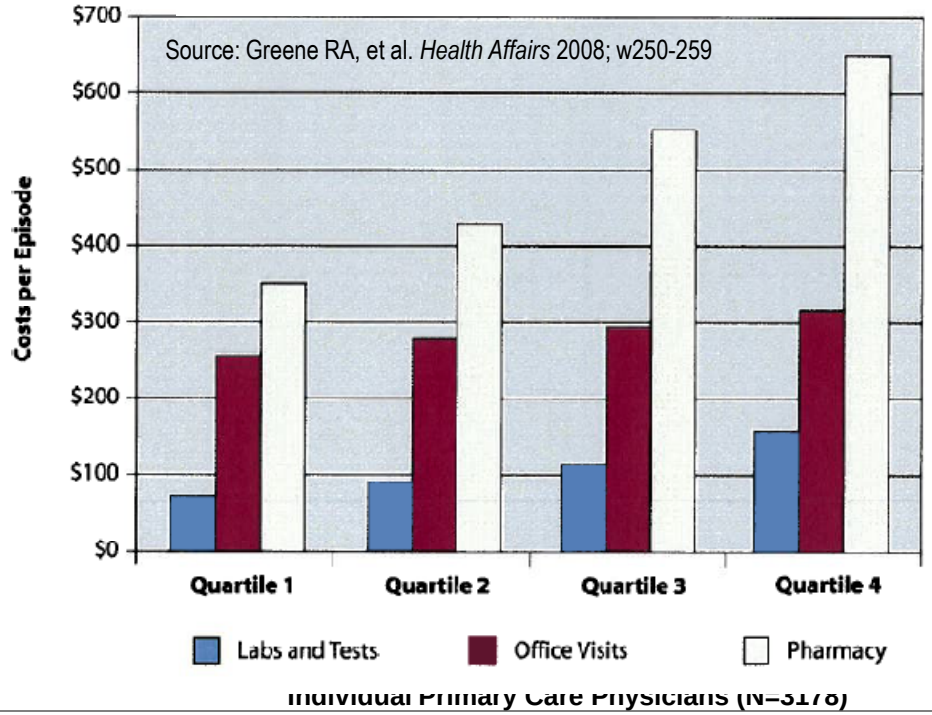
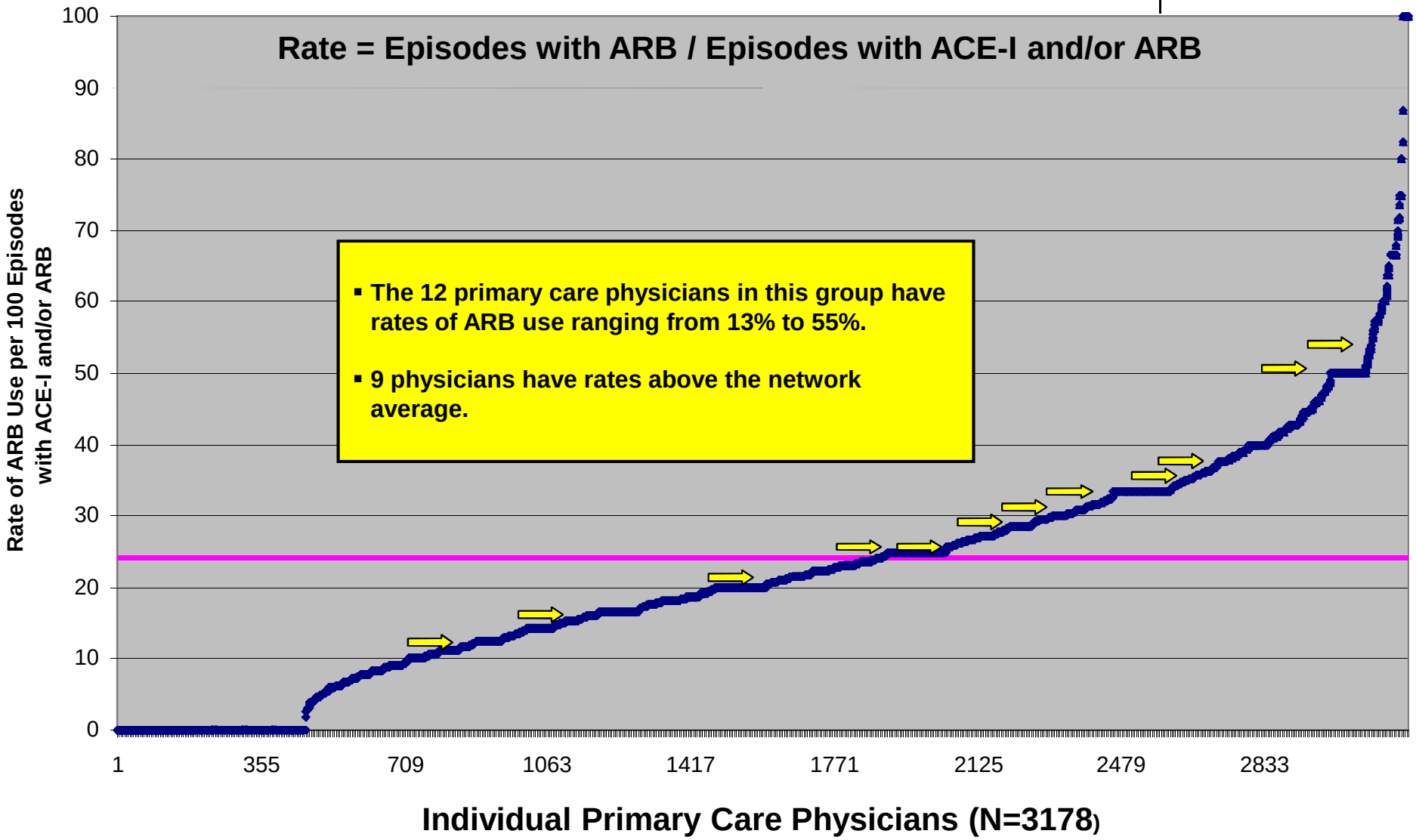
- Since 1970s, Wennberg et al. have called attention to unexplained practice pattern variations using maps
- Dr. Howard Beckman developed an analytic approach that makes the information clinically meaningful and actionable
- Clinically-specific, specialty-specific approach to displaying practice pattern variations – engages physician leaders and front line in physicians in addressing clinical waste
  - Referral tendencies, use of procedures, use of diagnostics, use of therapeutics
- This is a slow but critical process
- Payment models that create accountability for resource use (e.g., global budget) gives clinicians, groups and hospitals a strong incentive to act on these data



Benign Hypertension, With and Without Comorbidity
Individual Primary Care Physicians
Rate of ARB Use per 100 Episodes with ACE-I and/or ARB - 2007



Select PPVA Topics Provided to AQC Groups

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Condition	Primary Drivers of Variation			
	Rx	Imaging	Specialty Referral	Procedure
Hyperlipidemia	X		X	
Benign Hypertension	X	X	X	
Inflammation of Esophagus			X	X
Joint Degeneration of Knee			X	X
Depression	X			
Migraine	X	X	X	
Inflammation of Skin	X		X	X
CAD, Ischemic Heart Disease (except CHF, w/o AMI)	X	X	X	X
Sinusitis (Acute & Chronic), Allergic Rhinitis	X		X	X
Arthritis	X		X	
Low Back Pain	X	X	X	X

Avoidable Use of Hospital Resources
Ambulatory Care Sensitive Admissions
Non-Urgent Emergency Department Utilization
30 Day All-cause Readmissions

Summary & Next Steps

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- A payment model that establishes provider accountability for both medical spending and quality appears to be a powerful vehicle for realizing the goal of a high performance health care system with a sustainable rate of spending growth

- Rapid and substantial performance improvement appears to follow when:
  - Substantial financial incentives for improvement on well validated measures
  - Ongoing and timely data to inform improvement efforts
  - Organizational structure and leadership commitment to the goals

- BCBSMA will continue to develop, expand and refine the AQC model, including
  - Implementation in PPO
  - Align member incentives through product design
  - Supporting providers seeking similar model with other payers

- Employers can play a significant role in ensuring that ACOs meaningfully advance the twin goals of better quality and outcomes together with reduced spending growth
  - Insist ACOs develop in response to payment reform (not in anticipation)
  - Insist that payment reforms create true provider accountability for cost and quality

For More Information

Doctor and the Doll by Norman Rockwell

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